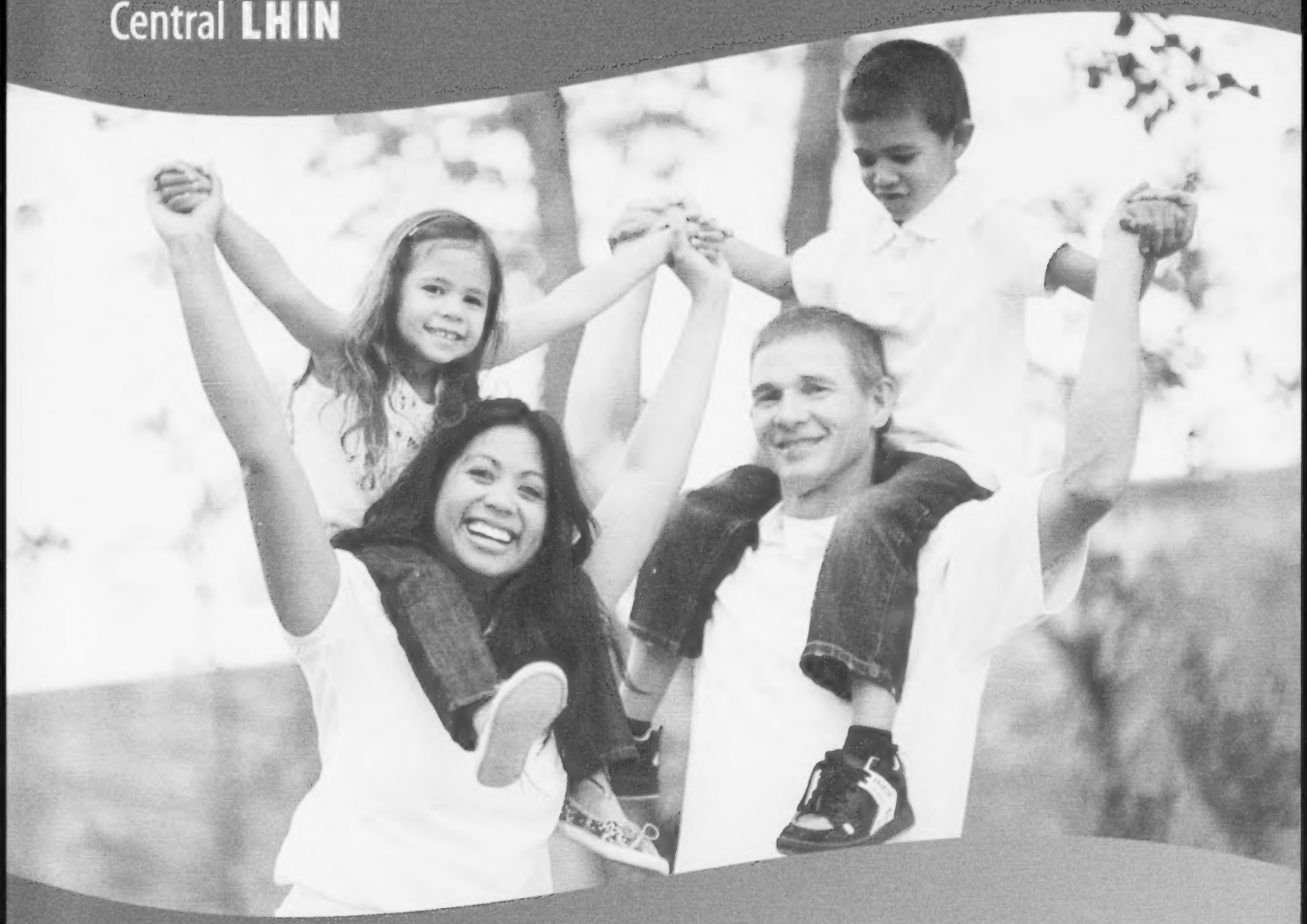
Central **LHIN**



Creating Caring Communities:

Advancing Excellence in Local Health Care *Together*

An Integrated Health Service Plan
for the Central Local Health Integration Network
2013-2016

Ontario
Local Health Integration Network

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Table of Contents

Chapter 1 2

Introduction

Improving local health care through quality and excellence

Chapter 2 5

Summary of Ontario's Action Plan for Health Care and the Provincial Context

Chapter 3 9

Central LHIN's Vision for Our Local Health System

What we can accomplish together

Chapter 4 11

Overview of the Current Local Health Care System and Achievements to Date

A snapshot of our local health system

Chapter 5 21

Quality-based System Directions for the Local Health System, including Specific Goals and How We Measure Success

A look at our quality framework and our four system directions

Chapter 6 31

Conclusion

Putting it all together

CHAPTER 1

Introduction

Improving local health care through quality and excellence

The Central Local Health Integration Network (LHIN) is one of 14 LHINs established in 2006 by the Ontario government to plan, coordinate, integrate and fund health services at the local level.

Our goal is to improve the health care system – to make it better for all of us who live, work and receive health care in our LHIN. Our success in achieving that goal depends on working together with our partners to establish a vision, develop a plan and help us translate our plan into action.

We first communicated our vision of *Caring Communities – Healthier People* when we launched our first Integrated Health Service Plan (IHSP) in 2007. We started building relationships with our health service providers, our communities and our colleagues at the Ministry of Health and Long-Term Care to move the plan from ideas to action. As Central LHIN has evolved, our approach to addressing local health challenges has matured.

The IHSP 2013-2016 outlines four quality-based system directions and four key enablers within a framework that supports the development of integrated health service provider communities that work together to improve care.

Four Quality-based System Directions

Appropriateness – Improve the delivery of safe, effective and timely care in the right setting;

Access – Continue to improve access to hospital, community and primary care services;

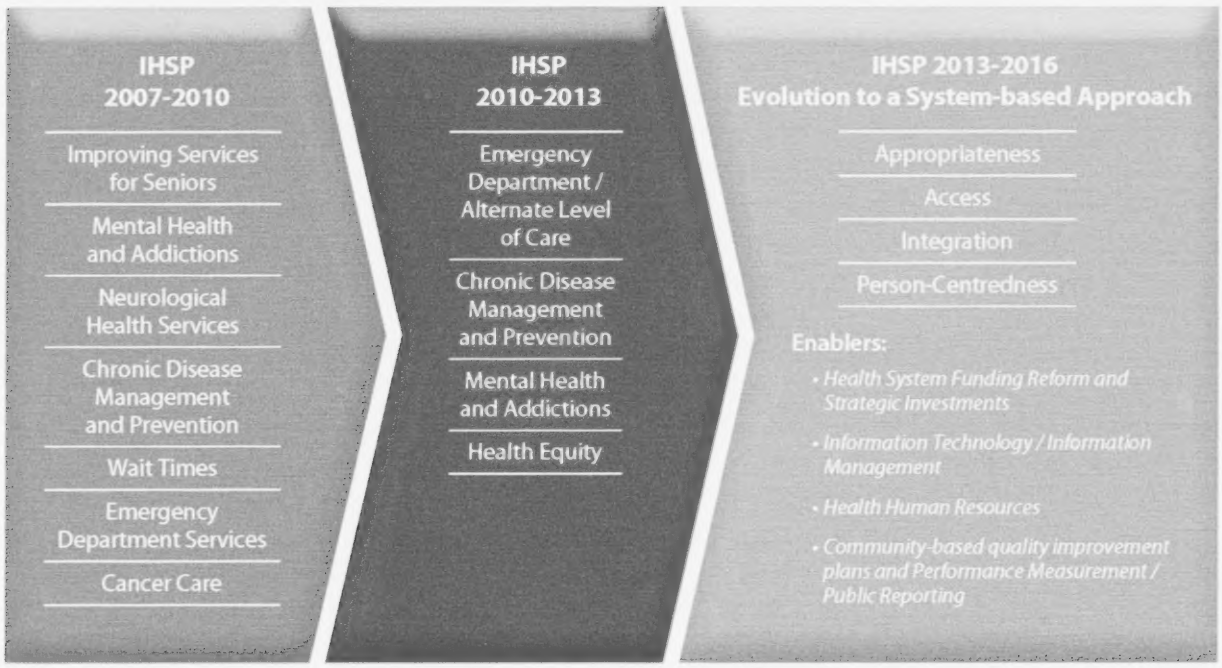
Integration – Strengthen integrated health care delivery from disease prevention and primary care through community, acute, long-term and end of life care; and

Person-Centredness – Improve equity in how people experience health care and service delivery.

Four Enablers

- Health System Funding Reform and Strategic Investments;
- Information Technology/Information Management;
- Health Human Resources; and
- Community-based quality improvement plans and Performance Measurement /Public Reporting

This plan builds on what we've learned and accomplished over the last seven years. It also supports the priorities of the Ministry of Health and Long-Term Care, linking provincial resources to local needs.



HOW WE DEVELOPED THIS PLAN

In 2012, the Ministry of Health and Long-Term Care Health Analytics Branch worked with the 14 LHINs to develop an Environmental Scan analyzing results of the 2006 and 2011 Census of Canada (Statistics Canada) data, as well as population estimates and projections from the Ministry of Finance. This updated information enabled us to build on the comprehensive Service Needs Assessment and Gap Analysis[1] completed in 2008. The review enhanced our understanding of Central LHIN's population structure by age, past and projected population growth, urban/rural population distribution, and addressed socio-economic concepts such as language, immigration trends, visible minority status, labour force, education and income.

Central LHIN's engagement with stakeholders is ongoing and the community engagement process to assist with the development of the new IHSP included a wide range of stakeholders. Key objectives included communicating the purpose and process for developing the IHSP, and seeking input on the framework that would establish the high level system directions, including critical success factors

1 KPMG. *Service Needs Assessment and Gap Analysis (SNAGA), 2008.*

for implementation. Consultations were held with hundreds of representatives of local health and community service providers, many of whom submitted formal input. People in our communities were also invited to have their say through a community engagement forum that included representatives of targeted population segments in our LHIN such as seniors, business organizations, members of visible minorities and groups representing diverse languages/cultures; and through an online and mail-in survey and feedback form. Through design, our public communication efforts, which included media relations, achieved a circulation to more than one million Central LHIN residents. However, feedback from the public was modest.

FROM PLAN TO ACTION

Stakeholder and community engagement helped us better understand the perspectives of those who provide and receive health services in our communities. These are important insights to have as we work to set clear, realistic and measurable outcomes for each of our quality-based system directions.

Our plan aligns with published provincial strategies, such as the *Action Plan for Health Care*, and has adopted provincial frameworks, including Health Quality Ontario's[2] quality framework and design attributes for a high-performing health system.

We will leverage our information management and information technology investments made at the local, regional and provincial levels to provide us with the data that will help inform the decisions on system planning. This includes a comprehensive process by which the data can be shared, reported and made available. The information management and information technology solutions that will be implemented in the next three years will be reflective of the IHSP's system directions.

Through health System Funding Reform, one of our key enablers, Ontario is moving away from the current global funding system towards what is known as Patient-Based Funding. Under Patient-Based Funding, health care organizations will be compensated based on how many patients they look after, the evidence-based quality of those services, and the specific needs of the population they serve. We will act on the IHSP in consideration of Health System Funding Reform and current fiscal challenges. Where possible, the LHIN will align funding to advance the IHSP.

Progress related to our IHSP will be reviewed on a regular basis. We will continue to engage with our partners so that the plan remains aligned and responsive to local needs.

Find out more: visit our website at www.centrallhin.on.ca.

2 Health Quality Ontario (HQO) is an Ontario government agency created in September 2005. HQO monitors and reports to Ontarians on: access to publicly funded health services; health human resources in publicly funded health services; consumer and population health status; and health system outcomes. The agency supports continuous quality improvement and promotes health care that is supported by the best available scientific evidence.

CHAPTER 2

Summary of Ontario's Action Plan for Health Care and the Provincial Context

As crown agencies that work in partnership with the Ministry of Health and Long-Term Care (MOHLTC), Local Health Integration Networks (LHINs) provide leadership and accountability for the health system at the local level.

This chapter summarizes current government priorities and the LHINs' contextual imperatives for developing the 2013-2016 Integrated health Service Plans (IHSPs).

Supporting the delivery of health care in a challenging environment and mandate for transformation

Ontario's LHINs allocate about half of the province's health care expenditures, or about $22 billion in funding as of 2011[3]. Working with the MOHLTC, LHINs align local and LHIN-wide plans with provincial priorities to improve access to health care and promote a sustainable health system.

Between 2003-04 and 2011-12, health sector funding in the provincial budget increased at an average rate of 6.1 per cent annually, for a total increase of $17.9 billion. However, the province now faces substantial fiscal pressures. To reduce expenditure growth, foster sustainability and manage those challenges, the government has stated that "funding for the health care system cannot continue to grow at past rates"[4]. This will require getting better value for money from all parts of the health care system to maintain access to services and continue to improve the quality of care.

Ontario's population is aging. As people get older, they tend to need more health care. In 10 years, there will be 43 per cent more seniors in the province than there are now and in 20 years, there will be twice as many[5]. Without changing how we deliver care, in 20 years the health system would cost $24 billion dollars more per year than we spend now[6]. Therefore, Ontario's LHINs are planning for changes to the system that support people receiving the right care at the right time in

3 Ministry of Finance. *Ministry of Health and Long Term Care THE ESTIMATES, 2011-12*. 2011.

4 Ministry of Finance. *2012 Ontario Budget*. Page 73. March 2012.

5 Ministry of Health and Long Term Care. *Ontario's Action Plan for Health Care*. Page. 5. January 2012.

6 Ministry of Health and Long Term Care. *Ontario's Action Plan for Health Care*. Page. 5. January 2012.

the right place, promote value for the dollar and encourage sustainable use of resources.

With fiscal and demographic pressures reinforcing the need to make changes now, several other important factors are currently aligned to provide support for implementation of the province's Action Plan for Health Care priorities (the Action Plan)[7]:

- A shared commitment among providers, administrators and frontline staff to make certain the system is ready for the challenges of the future;
- Embracing technologies that provide the new productivity tools and diagnostic techniques that support efficient ways of managing information; and
- Using the latest evidence and research to guide how resources are most effectively used and can best serve patient needs.

Provincial priorities and LHIN system imperatives

In January 2012, the province introduced Ontario's Action Plan for Health Care to manage spending growth while continuing to provide high-quality care to all Ontarians.

The Action Plan targets three priority areas:

- **Keeping Ontario Healthy**
- **Faster Access and a Stronger Link to Family Health Care; and**
- **Right Care, Right Time, Right Place**

Using these provincial priorities as a guide, each LHIN is developing local priorities and areas of focus.

Aligning the Action Plan with their IHSPs, Ontario's LHINs have collectively developed several **system imperatives** to reflect the Action Plan at a local level. These imperatives have been embedded in Central LHIN's quality-based system directions through to outcomes. Accountability will be tracked through system outcomes, accountability agreements and performance monitoring.

As outlined in our IHSP, LHINs will work in partnership with the MOHLTC and local stakeholders to foster a sustainable health system that delivers high-quality care and will be there for future generations.

The goal of the Action Plan is to create a "person-centred" health care system that offers evidence-based care, delivered in the right setting, and coordinated so that people receiving care from one provider to another do so seamlessly.

KEEPING ONTARIO HEALTHY

This Action Plan priority is about helping people stay healthy and supporting healthy lifestyles. In addition to tackling childhood obesity, smoking and cancer screening, it addresses chronic disease management, such as diabetes. LHINs across Ontario have been working with local providers on chronic disease prevention and management for many years. Measurable accomplishments have improved the way diabetes patients are treated through better coordination of care, and new resources for individuals and families are in place.

FASTER ACCESS AND A STRONGER LINK TO FAMILY HEALTH CARE

The family physician, nurse practitioner or local health care team is, ideally, the first point of contact with the health system when someone needs care, apart from an emergency. Outside of the hospital, it is also where follow-up care is received and referrals are made to specialized services. Ontario's Action Plan targets faster access to primary care, more ways to access family health care resources, such as telemedicine[8] points of contact, and new quality measures for family health care as a key component of an integrated system. The goal is to encourage appropriate care from family care providers to deliver the right care, at the right time, in the right place to improve patient outcomes and help reduce hospital readmissions.

7 Ministry of Health and Long-Term Care. *Ontario's Action Plan for Health Care.* Page. 6. January 2012.

8 Telemedicine connects people to health care professionals through the use of two-way videoconferencing. It allows people to get access to a specialist in a timely manner, receive care closer to home and reduce unnecessary travel.

Enhancing Access to Primary Care is an imperative that will help people get timely access to a primary care provider. It will also support appropriate use of hospital and clinic resources. Guided by the Action Plan's proposal to bring the organization of primary care under the mandate of the LHINs, planning for this outcome is spelled out in more detail in Chapter 5 of this IHSP, including how LHINs will measure success and how planned changes will have an impact.

Reducing hospital readmissions will improve sustainability of the health care system. In 2008-09, the rate for unplanned readmissions to hospital was 15 per cent in Ontario, which the Ministry considers high compared to other jurisdictions[9].

LHINs, working with local providers, can help integrate care more fully by developing ways to manage planning and accountability for the complete patient journey. The system leadership imperative, **Implementing Evidence-based Practice to Drive Quality**, will support consistent and coordinated responses to high-priority system safety issues. By reducing adverse events in all care settings (e.g. hospital, long-term care, community/home), Ontario's LHINs can build on existing patient safety initiatives. Partnering with Health Quality Ontario and other key stakeholders, LHINs will work to develop coordinated plans to reduce adverse incidents that impact quality of care and embrace the best evidence-based decision making.

RIGHT CARE, RIGHT TIME, RIGHT PLACE

The *Right Care* is informed by what the best scientific evidence and clinical guidelines have determined is the best care for an individual. It eliminates unnecessary procedures and tests, making resources available for those who need them most. The province and LHINs will work with Health Quality Ontario to translate evidence into tools and guidelines that put person-centred and evidence-based care into practice.

Care *at the Right Time* means appropriate access to needed care. This could be telemedicine or supports to help people stay at home longer, in the community or close to family and friends. This priority emphasizes preventative and proactive care so chronic conditions are managed, thereby reducing the number of hospitalizations a person will require, and easing the strain in emergency rooms and inpatient beds across the province.

Care *in the Right Place* addresses several system issues. One is the challenge of Alternate Level of Care (ALC)[10] – people who are in hospital beds, that no longer need to be there and would be best cared for in the community with supports to maintain and improve their quality of life. Community-based care is considerably less expensive and more appropriate than keeping an ALC person in a hospital bed. To support the Action Plan's goal of providing more community-based care for seniors, including those with chronic and complex conditions, the 2012 provincial budget has increased funding for home and community services by four per cent annually over the next three years[11]. Not only will this investment help individuals return to their homes after a hospital stay, community services help individuals stay healthy and in their home longer, reducing hospital and long-term care home admissions.

In order to provide increased community-based care, changes in funding of traditional health care providers will be required to make the system more person-centred. LHINs will work with hospital and community partners to transition procedures out of the high cost hospital setting into non-profit, community-based clinics. Furthermore, hospitals' base-budgets will be transitioned into person-centred funding where the provider is compensated for high-quality care and more efficient use of resources. LHINs will work with hospitals to manage this change, which began in April 2012.

9 MOHLTC presentation to Primary Care Leads. January 2012/Baker report.

10 When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation), the patient must be designated Alternate Level of Care (ALC) at that time by the physician or his/her delegate. The ALC wait period is determined by the hospital and starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies).

11 Ministry of Finance. *2012 Ontario Budget*. Page 28. March 2012.

To help address the fiscal concerns of the province, hospital base-budgets have been frozen; there will only be a two per cent increase in funding for certain activity-based initiatives, such as targeted wait-times reductions and priority treatments.

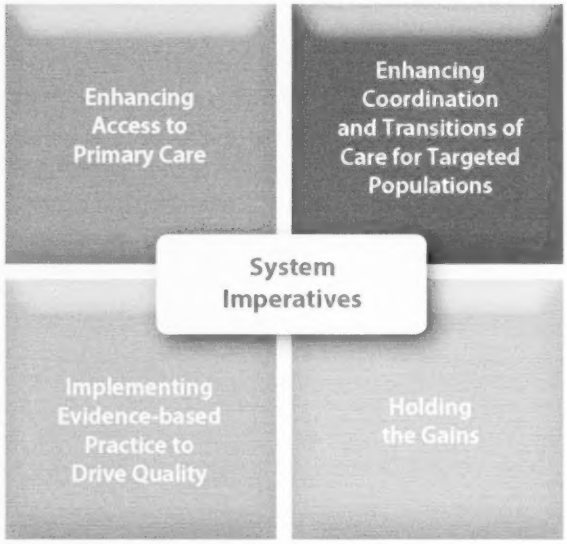
In addition, it is anticipated the province will launch a Seniors Strategy, building on the successes of the **Aging at Home** program. This will help prevent avoidable hospital admissions and readmissions. The expansion of community-based care and the call to empower LHINs to shift resources to where the need is greatest will be based on local needs and plans developed throughout this IHSP.

LHINs have a mandate to integrate the health care system, which will make it easier for people in Ontario to navigate care and access programs and services in a seamless manner.

Enhancing Coordination and Transitions of Care[12] is a LHIN system imperative that focuses on key populations of patients that have "high-needs"[13] of the health system due to their complex conditions and those at risk of becoming "high-needs" individuals. The health service providers will provide coordinated plans of care for these targeted populations to help them get the right care when and where they need it.

Three of the LHINs' strategic system imperatives align with the Action Plan's three priorities, providing local guidance for the Action Plan's provincial vision. A fourth LHIN system imperative, **Holding the Gains**, will help Ontario's LHINs make sound choices about local projects by verifying that achievements made to date are not lost as new priorities are developed and are appropriately moved forward. LHINs must be sure to protect the advances made in improving wait times, value for money, transparency and accountability.

LHINs' System Imperatives


Enhancing Access to Primary Care
Enhancing Coordination and Transitions of Care for Targeted Populations
System Imperatives
Implementing Evidence-based Practice to Drive Quality
Holding the Gains

Provincial Priorities, LHIN system imperatives and the IHSP

LHINs are committed to achieving a balance of the province's goals in the Action Plan, as reflected in the LHINs' system imperatives, and the needs of the LHIN's local communities. In this IHSP, they come together in a series of quality-based system directions that balance the needs of people in our communities, the input of our health service provider partners and key stakeholders.

12 A "transition of care" is the hand-off between providers and care teams as people move through their care journey.

13 "High needs" patients are those with complex conditions who require the highest medical and community support needs and account for most of the Province's health care costs.

CHAPTER 3

Central LHIN's Vision for Our Local Health System

What we can accomplish together

The Central LHIN vision of ***Caring Communities – Healthier People*** *was first articulated in our original Strategic Plan and supported through two consecutive planning periods, Integrated Health Service Plan (IHSP) 2007-2010 and IHSP 2010-2013. Through IHSP 2013-2016, Central LHIN continues to commit to achieving our vision of* ***Caring Communities – Healthier People*** *by supporting a local health system that is there for our residents when they need it, now and in the future. Over the next three years, we will do this by advancing quality and excellence in the delivery of services and supports to our community, and holding the gains we have achieved since our inception in 2005.*

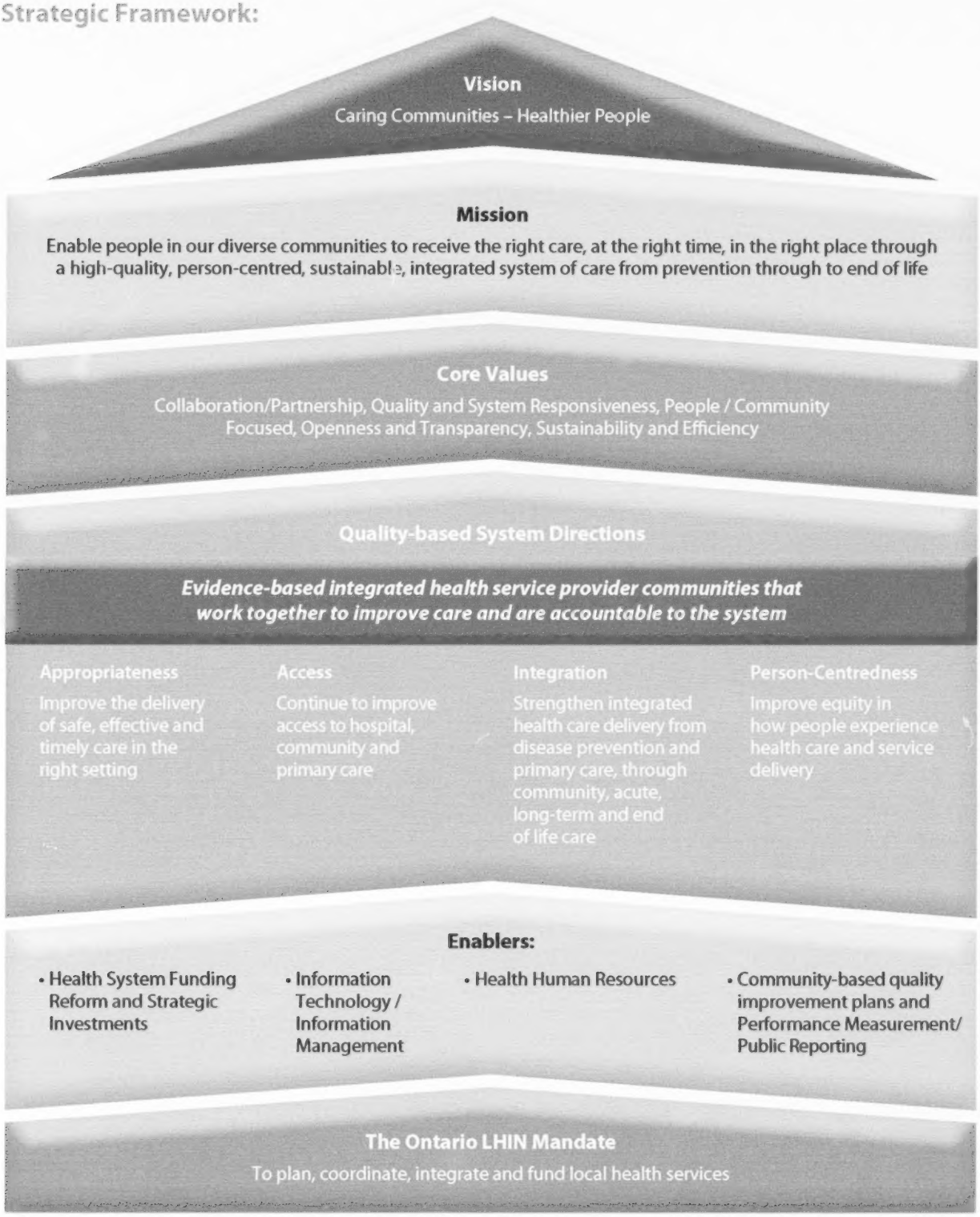
Our *Caring Community* will need to continue to work together – from our staff and Board of Directors to our health service providers and our residents – to push for excellence in achieving a high-quality, integrated health care system that is person-centred and sustainable for years to come, and that supports people in our communities from disease prevention to active care and end of life. The IHSP 2013-2016 is our shared roadmap to move us toward this vision.

Evolving as a community, we have recognized the need to focus our priorities at a system level to effect change across the continuum in order to achieve person-centred care. Through this work, four quality-based system directions have emerged within a strategic framework that will guide us for the next three years.

Working together to focus on these quality-based system directions over the next three years through integrated health service provider communities that work together to improve care will move us closer to our vision of *Caring Communities – Healthier People* and transform our health system to one that is sustainable for generations to come.

Find out more: to view Central LHIN's outcome map, visit www.centrallhin.on.ca

Strategic Framework:


Vision
Caring Communities – Healthier People
Mission
Enable people in our diverse communities to receive the right care, at the right time, in the right place through a high-quality, person-centred, sustainable, integrated system of care from prevention through to end of life
Core Values
Collaboration/Partnership, Quality and System Responsiveness, People / Community Focused, Openness and Transparency, Sustainability and Efficiency
Quality-based System Directions
Evidence-based integrated health service provider communities that work together to improve care and are accountable to the system
Appropriateness
Improve the delivery of safe, effective and timely care in the right setting
Access
Continue to improve access to hospital, community and primary care
Integration
Strengthen integrated health care delivery from disease prevention and primary care, through community, acute, long-term and end of life care
Person-Centredness
Improve equity in how people experience health care and service delivery
Enablers:
• Health System Funding Reform and Strategic Investments
• Information Technology / Information Management
• Health Human Resources
• Community-based quality improvement plans and Performance Measurement/ Public Reporting
The Ontario LHIN Mandate
To plan, coordinate, integrate and fund local health services

4

CHAPTER

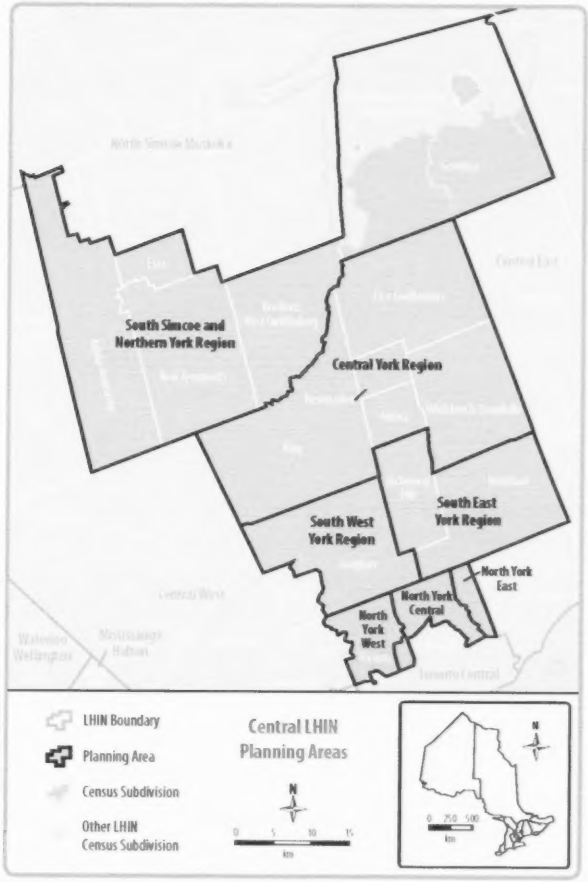
Overview of the Current Local Health Care System and Achievements to Date

A snapshot of our local health system

Having an understanding of the people living within Central LHIN, their health status and the health services currently available, helps us identify priorities, allocate resources effectively and make plans for the future.

Central LHIN covers an area of 2,730 square kilometers and is divided into seven planning areas, for planning purposes, as illustrated by the adjacent map. LHIN borders are not barriers to receiving service. In fact, nearly 30 per cent of Central LHIN hospital inpatients live outside the LHIN and over 30 per cent of Central LHIN residents receive care outside of the LHIN[14].

Each planning area has varying populations, age structures, economic conditions, health and social characteristics, requiring targeted approaches to respond to needs.



14 The Hay Group, Phase One Report, *Hospital Service Needs and Capacity Project*, June 2012.

Who lives in Central LHIN?

With a population of close to 1.8 million[15] (13.2 per cent[15] of all people who live in Ontario), Central LHIN has the most residents of all LHINs and is among the most diverse and one of the fastest growing. Among the three regions represented in our LHIN – South Simcoe/Northern York (population of 117,488[16]), North York (population, 673,688[16]), and York Region (population, 1,014,374[16]), most people in our LHIN (88.7 per cent[15]) live in a large urban centre; only 4.5 per cent[15] dwell in a rural area. Almost 40 per cent[15] reside in the city of Toronto, 17 per cent[15] in Markham, 14 per cent[15] in Vaughan, and 11 per cent[15] in Richmond Hill. Although Central LHIN is primarily urban, there is a significant rural area in the north, which can present challenges to residents when accessing services.

Between 2006 and 2011, the LHINs population increased by almost 11 per cent[15]. This was the highest increase in population and the third highest growth rate among LHINs. Between 2011 and 2016, our population will increase by 180,800 residents (10.1 per cent[15]) by 2016; by 2021, the population will have grown by 20.3 per cent[15] since 2011 – one of the highest projected rates among the LHINs.

We will experience greater-than-average population aging in Central LHIN over the next 10 years. Currently, 12.5 per cent[15] of people (221,068) in the LHIN are seniors aged 65 or higher. This puts Central among the top three LHINs in terms of absolute numbers of seniors. By 2016, seniors will constitute 14.3 per cent[15] of our population; and by 2021, they will comprise 16.1 per cent[15] (342,538) of all residents. By sub-LHIN regions, the highest proportion of the population over the age of 65 is in North York Central (17 per cent), followed by North York East (16 per cent) and North York West (15 per cent).

In addition, the Better Outcomes Registry and Network (BORN) Ontario[17], *Perinatal Health Report 2009-2010*, indicated that Central LHIN had the highest number of births (18,919) of all LHIN regions and the second highest number of births within Central LHIN hospitals (18,453), following Toronto Central LHIN (19,871). The 2011 census showed[15] that 13.6 per cent of children between 0-4 years of age (96,095) reside in Central LHIN, comprising 5.6 per cent of our total population. This is the highest of proportion of all of the LHINs. Within the sub-LHIN regions, the highest proportion as a percentage of the total Central LHIN population aged 0-4, is in South West York Region (17.5 per cent), followed by Markham (17.1 percent) and North York West (16.3 per cent). By 2016, the absolute number of children in this age range will increase to 110,507 and by 2021, it will increase to 122,512. By 2031, the 0-4; 0-19 age group will grow by 35.7 per cent, the third highest amongst the LHINs[15].

Population characteristics

Central has the largest proportion of immigrants (48 per cent of residents[15]) among the LHINs, and the second highest visible minority population (42 per cent of residents[15]). We have the highest proportion of residents (4.5 per cent[15]) who report no knowledge of either official language.

In 2006, just over half of the LHIN's population reported English as their mother tongue[15] (the lowest rate among the LHINs) and only 1.2 per cent[15] included French as their mother tongue (the second lowest percentage in Ontario). We also have the lowest number (0.4 per cent[15]) of Aboriginal/First Nations people.

The LHIN's working-age population is relatively well educated; the proportion of residents who do not have a completed certificate, diploma or degree is among the lowest in the province and the proportion that has completed post-secondary education is among the highest.

The proportion of the population considered "low-income" is the second highest in Ontario, at almost 18 per cent[15]. Among children, poverty rates are even higher in some parts of our LHIN. In Markam-Unionville, 22.5 per cent of children live in poverty; in Richmond Hill, the rate is nearly 20 per cent[18].

15 Ministry of Health and Long Term Care Health Analytics Branch analysis of Census of Canada (Statistics Canada) 2006 and 2011 data; Ministry of Finance population estimates and projections.

16 *Environics Analytics 2012*

17 Better Outcomes Registry & Network (BORN) Ontario, *Perinatal Health Report 2009-2010*. August 2011.

18 Data from the Action on Poverty Series, created by Social Planning Toronto, York Region's Social Planning Council, the Do the Math working group and Human Services Planning Board.

Our service providers deliver care to many people who live outside our LHIN, and other LHINs provide care to many of our residents because LHIN geographic borders do not pose barriers to access.

Because Central LHIN's planning areas are so different, each has their own unique challenges and needs that must be considered when planning at a system level.

The need to provide culturally and linguistically appropriate services for our diverse communities is greatest in Toronto, Markham and Vaughan.

Central LHIN Population Factors Compared to the Province*

	Central LHIN	Ontario
Total Population 2011	1,768,550	13,372,996
Population Aged 65+	12.5%	14.2%
Population Aged 75+	5.8%	6.6%
Population English Mother Tongue	51.5%	69.8%
Population French Mother Tongue	1.2%	4.4%
Population with no knowledge of either official language	4.5%	2.2%
Population Immigrants	48%	28.3%
Population Visible Minority	42.1%	22.8%
Population Aboriginal Identity	0.4%	2%
Population Completed Post-Secondary Education, aged 25-64	66.6%	61.4%
Population Living in Low Income	17.7%	14.7%

*Source: Ministry of Health and Long Term Care Health Analytics Branch analysis of Census of Canada (Statistics Canada) 2006 and 2011 data; Ministry of Finance population estimates and projections

The health of our population

Examining Central LHIN's health profile helps us work towards our goal of reducing health disparities and improving equitable access to health care by identifying populations that would benefit from focused initiatives.

Generally, our residents have a significantly lower incidence of heart disease, arthritis and multiple chronic conditions than that of Ontario as a whole, and rank among the lowest across LHIN areas. Central LHIN residents have the highest life expectancy at birth of 83.6 years[19] and the second highest life expectancy at age 65[19]. However, social determinants of health, such as unemployment, education levels and risk behaviours – such as smoking, obesity and inactivity have all been shown to affect how healthy people are. Within our planning areas there are variations in health status due to the differences in these characteristics.

According to the Canadian Institutes of Health Research, high risk populations are groups of people that share characteristics – such as homelessness, single women living in poverty or lone-parent families – associated with high risk of adverse health outcomes. Two of our planning areas – South Simcoe/Northern York Region and North York West – have been identified as high risk populations from a population health standpoint.

19 Ministry of Health and Long Term Care Health Analytics Branch analysis of Census of Canada (Statistics Canada) 2006 and 2011 data; Ministry of Finance population estimates and projections.

A higher number of residents in these two planning areas face serious chronic diseases, as well as obstacles to accessing primary care, compared to other planning areas in the LHIN.

Central LHIN's prevalence rates for smoking, heavy drinking and overweight/obesity are the second lowest among the LHINs[20]. Approximately 16 per cent[20] of residents are smokers, 11 per cent[20] are heavy drinkers and 47 per cent[20] are overweight or obese. However, the prevalence of physical inactivity is among the highest in the LHINs, and significantly higher than the provincial average[20]. Lack of physical activity is a risk factor for many cancers and chronic conditions including diabetes, heart disease and stroke. Heart disease, stroke and some cancers – such as lung, colon and lymphoma – are leading causes of death and potential years of life lost in our LHIN.

The growing health needs of our aging population will significantly impact Central LHIN over the next five to 10 years and beyond. The prevalence of multiple chronic conditions increases dramatically with age. Nearly 40 per cent[20] of current Central LHIN residents aged 65-74 and 56 per cent of those aged 75 plus have two or more chronic conditions. These conditions account for six out of 10 deaths[20], 20 per cent[20] of acute hospital discharges, and 25 per cent[20] of acute hospital days for our residents.

As in most LHINs, the largest percentage increase in use of services by people in Central LHIN will be in sectors associated with older persons. However, a large young and growing population in Central LHIN will also require a responsiveness to the types of paediatric services needed to support this cohort to access health care and services in the LHIN.

The health service providers in our LHIN

The mandate of the LHIN is defined by the *Local Health System Integration Act*, 2006, which also describes which agencies fall under the LHIN's mandate. A key role for our LHIN is to facilitate integration within the health system. We do this in part by actively encouraging our health service providers to seek opportunities to collaborate and partner with other health service providers.

Central LHIN has 110 service accountability agreements in place with our health service providers for the delivery of a range of programs and services across the continuum of care. Some of our providers operate facilities within multiple sectors. The breakdown is as follows:

- Six public and three private hospitals;
- 46 long-term care homes;
- 33 community support service providers;
- 20 mental health and addictions service providers;
- One community care access centre (CCAC); and
- Two community health centres.

In addition, the Ministry of Health and Long-Term Care (MOHLTC) has recently transitioned the Diabetes Regional Coordinating Centres to the LHINs.

Many MOHTLC-funded services currently do not fall under our mandate as defined by the *Local Health System Integration Act, 2006*, including:

- Most physician services;
- Nurse practitioner led clinics;
- Drug benefits;
- Independent health facilities;
- Laboratories;
- Ambulance services; and
- Public health.

Our health service providers list is on our website at www.centrallhin.on.ca.

20 Ministry of Health and Long Term Care Health Analytics Branch analysis of Census of Canada (Statistics Canada) 2006 and 2011 data; Ministry of Finance population estimates and projections.

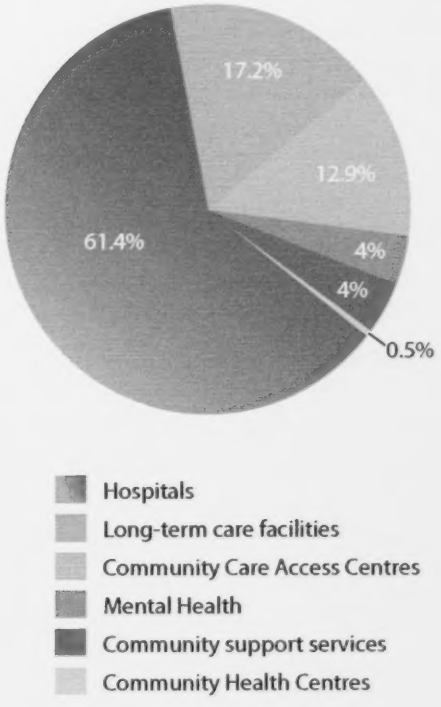
Our health service provider budget

For 2012-13, Central LHIN's budget is approximately $1.8 billion to allocate across a range of health programs. We spend 99.73 per cent of our funding on health service providers; the remainder is LHIN operations. Hospitals account for the majority of spending, at 62.2 per cent, or a little over $1.0 billion.

Our residents represent 13 per cent of Ontario's population. However, in 2011-2012, the budget for our health service programs was only 7.66 per cent of provincial health expenditures. This is the third lowest per capita funding among the LHINs.

Over time, we expect that collaboration among neighbouring LHINs will continue to help us align available health services and resources to improve efficiencies through information sharing and joint planning.

2012-13 health sector budget as a percentage of Central LHIN's total budget



Our achievements

In our 2010-2013 HISP, we identified four priorities:

- Emergency Department and Alternate Level of Care;
- Chronic Disease Management and Prevention;
- Mental Health and Addictions; and
- Health Equity.

What we did to advance our priorities

Emergency Department and Alternate Level of Care

REDUCED EMERGENCY DEPARTMENT WAIT TIMES:

Central LHIN invested in, and all local hospitals and the Central CCAC participated in, the provincial Emergency Room Pay for Results program designed to improve emergency room performance.

As a result, emergency department wait times for admitted high acuity (seriously ill) patients improved by 23 per cent, or 9.5 hours (second quarter 2012-13 results as compared to full-fiscal 2011-12). Wait times for non-admitted patients with complex and minor uncomplicated conditions both improved: by 3.7 per cent for non-admitted high-acuity patients; and by 3.2 per cent for non-admitted low acuity patients (second quarter 2012-13 results as compared to full fiscal 2011-12).

REDUCED NON-URGENT EMERGENCY DEPARTMENT VISITS:

A partnership between North York General Hospital (NYGH), Saint Elizabeth Health Care, Access 1 and Toronto North Support Services developed an Emergency Department (ED) Diversion Program[21] to seamlessly connect people with mental health issues to the appropriate community services. As a result, 91 per cent of those who used the NYGH program had no mental-health related returns to the ED within 28 days, representing a 53 per cent reduction in ED revisit rates. The program has since been expanded to Humber River Regional Hospital.

IMPROVED ACCESS TO HOSPITAL SERVICES:

The Canadian Institute for Health Information (CIHI)[22] Health Indicators 2012 report displays results at the LHIN level based on where people live. Tracking of 35 indicators, including those related to hospital access, shows Central LHIN performed statistically significantly better than both Ontario and Canada overall.

The Health Quality Ontario *Quality Monitor – 2012 Report on Ontario's Health System* showed that Central LHIN performed average or better-than-average on most of the reported health indicators, including those related to access.

Through an e-referral[23] system, referrals are now being managed electronically. This allows all Central LHIN hospitals and Central CCAC to work smarter and safer, and to help people get the right care at the right time and in the right place. Pre-implementation data gathering efforts suggest that approximately 60 per cent of paper-based referrals were deemed complete upon initial submission. Since implementation of e-referral, we have increased our referral accuracy by 20 per cent as of September 2012. This initiative supports Ontario's Action Plan for Health Care and is aligned with the province's commitment to create electronic health records for all Ontarians by 2015, and represents the next generation of the health care referral process. Recently, the e-referral Project Implementation Team at Central CCAC won a Systems Partnership Award of Excellence from the Ontario Association of Community Care Access Centres for this groundbreaking work. With more than 40,000 referrals to the Central CCAC alone each year, e-referral offers greater consistency, reliability, faster access, as well as tracking and reporting on referral precision and completeness.

The Central LHIN hospital/CCAC leadership forum oversaw two planning projects to better understand the hospital services people will need in the future. One project, the Hospital Service Needs and Capacity Planning Project, looked at the projected population growth in our LHIN to 2031 and its impact on required hospital services. It also considered the possible impact of strategies that could help reduce reliance on hospitals for care.

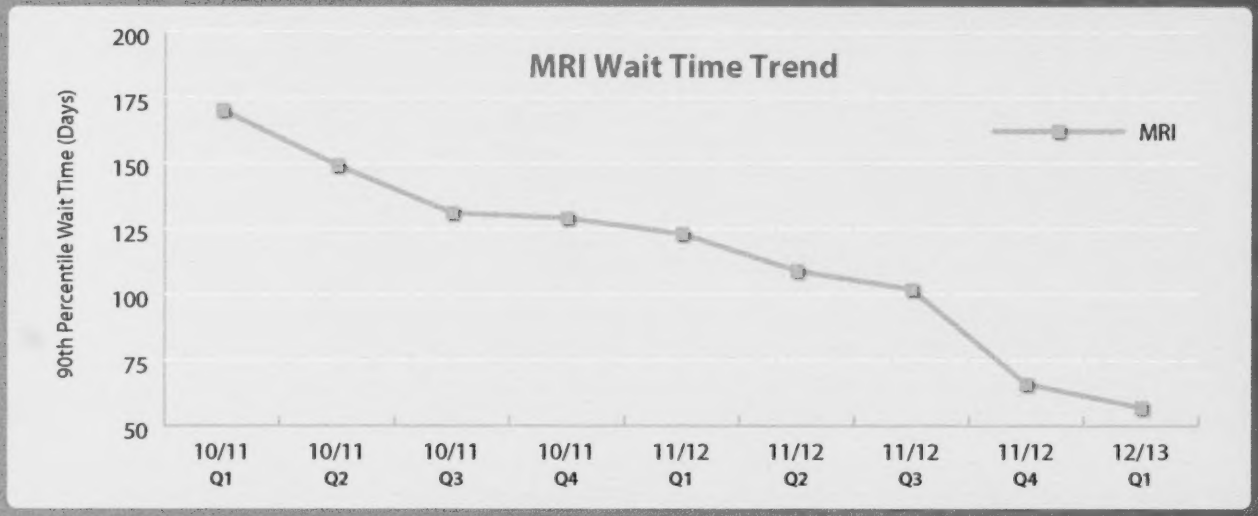
A second project that was overseen by the hospital/CCAC leadership forum was a collaborative LHIN-wide ALC/Rehab planning initiative to better understand inpatient and outpatient rehabilitation needs for residents of Central LHIN, with a related goal of identifying and addressing the specific causes of rehabilitation-related Alternate Level of Care (ALC) days. This project aims to achieve earlier access to the right care across settings and better outcomes for people who need rehabilitation following total joint replacement and hip fracture surgery, or who have had a stroke or other conditions that benefit from rehabilitation.

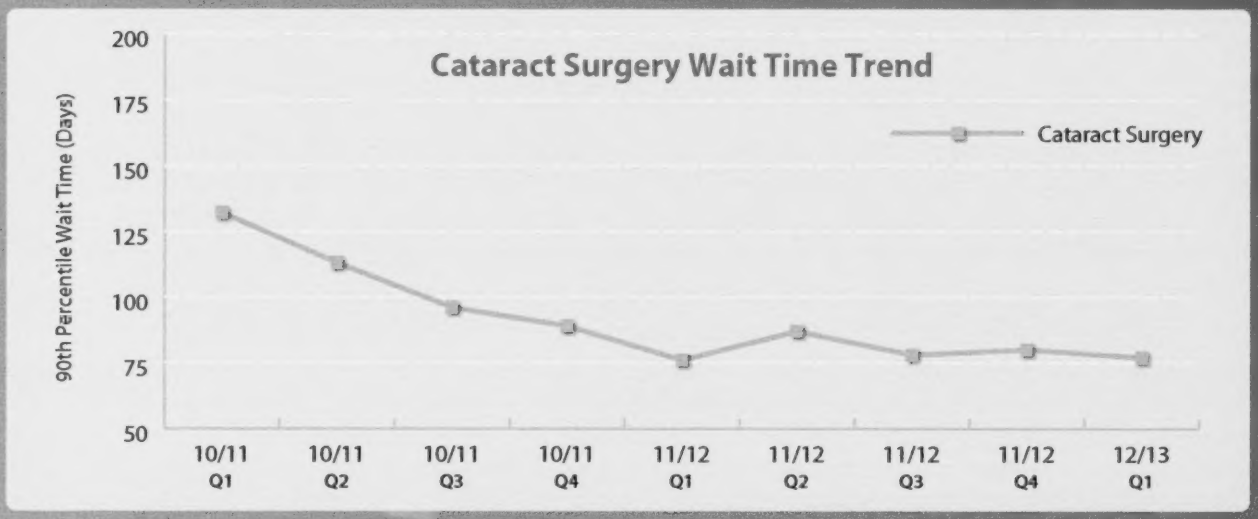
21 An Emergency Department (ED) Diversion program is focused on improving the coordination of care delivery between acute care and community-based supports.

22 The Canadian Institute for Health Information (CIHI) collects and analyzes information on health and health care in Canada and makes it publicly available. Canada's federal, provincial and territorial governments created CIHI as a not-for-profit, independent organization dedicated to forging a common approach to Canadian health information.

23 E-referral is an electronic referral system that allows hospitals, rehab facilities and community service providers to share information quickly, precisely and reliably, so that people get faster and more equitable access to appropriate care when leaving an acute care setting.

Central LHIN Wait Times Have Improved





RELIEVED ALTERNATE LEVEL OF CARE (ALC) PRESSURES IN HOSPITALS:

Central LHIN has worked with our health service providers and the Ministry of Health and Long-Term Care to build capacity in our local system to reduce ALC pressures and ensure people get the care they need at the right time and right place.

In 2011-12, Central LHIN invested $52.9 million through 62 **Aging at Home** initiatives. One hundred and forty-five new transitional care beds were created to assist with people who are discharged from the hospital and waiting for long-term care or other destinations. Further new physical bed capacity was created through the home ventilation program, behavioural support unit and community alternatives to long-term care such as the **Home First** program. Key community-based services were continued. As a result, major progress was made in discharging patients with long ALC stays in acute care hospitals. In 2011-12, 539 ALC long stay patients (greater than 40 days) were discharged from our acute care hospitals.

Central LHIN was one of the first LHINs to implement **Home First**, an enhanced care service offered by the Central CCAC in partnership with Central LHIN hospitals. **Home First** has served more than 1,758 clients since its implementation in September 2009. On average, nearly 70 per cent or more of Home First clients remain in the community after receiving enhanced care, thus reducing the need for long-term care.

Four new beds were opened at West Part Healthcare Centre to provide assessment and rehabilitation support for ALC patients in intensive care units (ICU) who need mechanical ventilation and cannot be discharged to the community right away. This program has brought 17 people home and has created additional capacity of 5,171 days in hospital ICUs.

Chronic Disease Management and Prevention

IMPROVED CHRONIC DISEASE MANAGEMENT AND PREVENTION:

Under the Ontario Diabetes Strategy (ODS), Central LHIN has worked with the Diabetes Regional Coordinating Centre (DRCC), the Self-Management Initiative and the Centre for Complex Diabetes Care (CCDC) to improve the quality of service for residents with diabetes and those who are at risk of developing diabetes. Under ODS, a pilot program provided self-management education and training to people living with a mental health condition who have, or are at risk of, developing diabetes, in partnership with The Lance Krasman Centre. Central LHIN also worked with Central-East and North Simcoe Muskoka LHINs, the Entité de planification des services de santé en français #1 Centre Sud-Ouest (Entité1) and our health services providers to jointly organize a Francophone Peer Leader Training session on Chronic Disease Self-Management Program in September 2012. The seven leaders who graduated from the program will hold chronic disease self-management workshops for our local francophone communities.

The LHIN has worked with the Central Regional Renal Steering Committee under the Ontario Renal Network to expand dialysis services, and planning is underway to establish a Specialty Unit for residents on dialysis living in long-term care. The LHIN has also supported the expansion of five stroke prevention clinics to include access to cardiovascular rehabilitation services, recognizing the link between stroke and vascular health conditions. In addition, the LHIN supported hospitals to develop a stroke action plan to enhance timely access to rehabilitation services and improved stroke outcomes.

In December 2011, Central LHIN convened the Complex Care Planning Group, created to address challenges surrounding community-based complex care, with the goal of fostering better coordination of services for people with complex care needs. The Planning Group consists of representation from Central LHIN, the Ministry of Health and Long-Term

Care and the Ministry of Community and Social Services. As a key deliverable, the Complex Care Planning Group will develop a set of recommendations for system improvement.

Additionally, Central LHIN recently funded the Ontario March of Dimes to implement a new model of care, *Cluster care for younger adults with complex medical needs*, that will provide services for individuals residing in a congregate/cluster setting. Around-the-clock care for these individuals will include nursing, personal support and other health services, as well as significant care coordination. This integrated and comprehensive model of service delivery will foster a healthy and supportive living environment. The initial location for the cluster care units will be the recently opened Reena Community Residence in Vaughan.

Mental Health and Addictions

IMPROVED ACCESS TO MENTAL HEALTH AND ADDICTIONS SERVICES:

Central LHIN has continued to focus resources where they make the greatest impact – coordinating care, bridging gaps in the system, reducing wait times for assessment and services, and enhancing community supports. Central LHIN's priorities have been consistent with the provincial government's *Comprehensive Mental Health and Addictions Strategy* that includes supporting programs and initiatives that improve the health and wellbeing of all Ontarians, reduce the incidence of mental illness and addictions, identify mental health and addictions early, and intervene appropriately.

Central LHIN has seen improved diversion of repeat visits to the emergency department as a result of the Emergency Department Diversion Program at North York General Hospital and Humber River Regional Hospital, an initiative which focuses on improving the coordination of care delivery between acute care and community-based supports for mental health clients. In addition, expansion of supportive housing units across the LHIN in both the North York West (Jane/Finch) area and in Bradford is an important component to meeting the needs of people living with mental health and/or addictions issues. The LHIN invested in the expansion of community mental health eating disorders programs, including the addition of three new nurse practitioners, more paediatric inpatient beds and enhanced adult outpatient services across Central LHIN.

York Support Services Network (York Region) and Access 1 (North York and Scarborough) are providing a single point of access to case management and assertive community treatment teams, with a single application and a single wait list. Central West LHIN and Toronto Central LHIN have now adopted this program that was created in the Central LHIN.

As Central LHIN's population is aging and the number of people with cognitive impairment is growing, the LHIN, under the Behavioural Supports Ontario initiative, enhanced resources by $4 million and committed to improving care for people living with challenging behaviours associated with mental health, addictions, dementia or other neurological conditions as outlined in our Central LHIN Behavioural Supports Ontario Action Plan.

Health Equity

ENHANCED EQUITY IN ACCESS TO CARE:

Central LHIN supported three new Family Health Teams (Don Mills, Humber River Regional Hospital and Woodbridge Medical Centre) and two Nurse-Practitioner Led Clinics (Sutton and North York West) to become fully operational. Central LHIN has one of the highest Health Care Connect[24] (HCC) referral rates for the senior population 65 years and older (93.71 per cent) and we improved matching of unattached patients through HCC by 10 per cent. We also successfully piloted the Health Equity Impact Assessment (HEIA)[25] tool. In addition, a joint action plan was developed with the Entité1 in collaboration with North Simcoe Muskoka and Central East LHINs, and a multidisciplinary Newcomer Settlement planning group was established to provide recommendations on addressing this group plan.

We have accomplished a lot together in Central LHIN to move toward our vision of caring communities and healthier people. But there is room for continued improvement. More work needs to be done to transform our health care system into one that enables people in our diverse communities to receive the right care, at the right time, in the right place through a high-quality, person-centred, sustainable, integrated system of care.

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24 Health Care Connect helps Ontarians who are without a family health care provider (family doctor or nurse practitioner) to find one who is accepting new patients in their community. To join the program, phone 1-800-445-1822 or register online at www.ontario.ca/healthcareconnect.

25 The Health Equity Impact Assessment (HEIA) tool is a decision support tool which walks users through the steps of identifying how a program, policy or similar initiative will impact population groups in different ways. HEIA surfaces unintended potential impacts. The end goal is to maximize positive impacts and reduce negative impacts that could potentially widen health disparities between population groups — in short, more equitable delivery of the program, service, policy etc. Effective use of HEIA is dependent on good evidence.

5 CHAPTER

Quality-based System Directions for the Local Health System, including Specific Goals and How We Measure Success

A look at our quality framework and our four system directions

Health Quality Ontario (HQO) defines a high-performing health system through nine attributes that are embedded within Central LHIN's quality-based system directions and will guide the development of future quality measures at the system level. We have adopted and incorporated the attributes[26] into our planning as is evident in our strategic framework (Chapter 4).

The Central LHIN's 2013-2016 Integrated Health Service Plan (IHSP) grounds our four system directions within our Action Plan to Improve Quality[27], while aligning with Ministry of Health and Long-Term Care (MOHLTC) priorities and incorporating local needs. Four key enablers will help transform the local health system into one that is quality-focused, sustainable, person-centred and delivers the right care, in the right time, at the right place.

26 Health Quality Ontario. *Quality Monitor 2012 Report on Ontario's Health System.* June 2012. The report defines the nine attributes as accessible, effective, safe, patient-centred, equitable, efficient, appropriately resourced, integrated, and focused on population health.

27 Central LHIN. *Patients First: An Action Plan to Improve Quality in the Transitions of Care.* August 2011. The plan has three main strategies: strengthening relationships to support a culture of quality improvement – health service provider quality collaboratives; standardizing hospital discharge processes; and developing indicators for transitions of care.

OUR CENTRAL LHIN QUALITY FRAMEWORK		
Goal **What we want to do**	**Actions** **How we're going to do it**	**Outcomes** **What it could look like**
Align performance goals across the LHIN with provincial priorities and evaluate to support shared consistent direction to achieve a high-performing health system.	• Implement provincially developed system-level performance indicators to support provincial and local priorities; align with the MOHLTC direction, Ministry-LHIN Performance Agreements (MLPAs) • Include a mechanism for regular evaluation of initiatives against system outcomes indicators • Align all service accountability agreements with provincial and LHIN performance indicators • Support the provincial initiative to fast-track action on Quality Improvement Plans (QIPs) in primary care that align with provincial and regional goals and performance indicators • Use evidence to drive decisions	**Beyond the next three years, we will have…** • A system that delivers the right care, at the right time, in the right place to achieve better outcomes for people • An integrated system that makes decisions based on evidence • A system that provides better value – the optimization of clinical and population benefit and system cost • A system that is focused on what the person needs throughout the continuum of care

Our Quality-based System Directions

Our quality-based system directions were determined through an understanding of the MOHLTC goals, analysis of data on the provincial and LHIN-specific indicators, review of specific consultation reports such as the Walker[28] and Baker[29] reports, and engagement with local communities and health service providers.

The system directions were selected based on:

- Alignment with provincial priorities;
- Immediate or future system impact; and
- Needs within our community.

The following table describes current directions for Central LHIN and the types of improvements sought.

28 Dr. David Walker. *Caring for Our Aging Population and Addressing Alternate Level of Care*. Report submitted to the Ministry of Health and Long Term Care June 30, 2011.

29 Dr. G. Ross Baker Chair. *Enhancing the Continuum of Care – Report of the Avoidable Hospitalization Advisory Panel*. Submitted to the Ministry of Health and Long Term Care in November 2011.

System Direction	Where we are
Appropriateness Improve the delivery of safe, effective and timely care in the right setting	• Average or better-than-average performance on most safety and effectiveness indicators • A majority of palliative care[30] patients indicate a preference to die at home, but a minority actually do • Seniors spend too much time in settings where they experience decline after an acute hospital admission • Room for improvement
Access Continue to improve access to hospital, community and primary care services	• Holding gains in most emergency department (ED), surgical and diagnostic wait times • Room for improvement, especially in lowering Alternate Level of Care (ALC) days and ED wait times for admitted patients • Average primary care wait times[31]
Integration Strengthen integrated health care delivery from disease prevention and primary care, through community, acute, long-term care and end of life care	• Provider-centred service delivery design • Fragmented system that lacks coordination and accountability between sectors • Complex patients experience difficulty as they transition through services • Minimal linkage between primary care and public health and LHIN-funded service delivery
Person-Centredness Improve equity in how people experience health care and service delivery	• Provider-centric system • Hard to navigate the system and lack of knowledge about where to find services • Variations in levels of services provided

In the following pages, we outline our strategy, goals and measures within each quality-based system direction.

APPROPRIATENESS

Central LHIN has made significant gains in improving patient safety and effectiveness outcomes since our first IHSP was developed (2007-2010). As we've said, the Health Quality Ontario *2012 Quality Monitor* showed average to better-than-average results in Central LHIN for most indicators. However, more needs to be done to provide appropriate care for people with complex and chronic conditions.

Managing complex or chronic care needs through primary care with community supports can prevent escalation to the point of hospital admission.

30 Palliative care is an approach to care for people who are living with a life threatening illness, regardless of age. The focus of care is on achieving comfort and ensuring respect for the person nearing death and maximizing quality of life for the person, their family and loved ones.

31 Health Quality Ontario. *Quality Monitor – 2011 Report on Ontario's Health System.* Pages 28, 174. June 2011. On average, less than 50 per cent of Ontarians could book a same/next day appointment with their doctor the last time they were sick or needed medical attention. Central LHIN results were average.

In addition, people in hospital should be discharged, when medically appropriate, to settings that provide care that is consistent with their needs.

ACCESS

The health system functions as a continuum. Every part is dependent on flow through, and access to, another part of the system. To maintain and improve how the system works, emergency departments, hospitals, post-acute and rehabilitation services and supports, primary care, long-term care, community care and palliative care must work together to deliver access to the appropriate supports when needed.

Moving people through the emergency department depends in part on a hospital's ability to either admit patients to acute care beds, or discharge them to appropriate destinations (for example, rehab, back home and/or in the community with appropriate supports). By the same token, access to effective primary care and community supports decreases the need for urgent access to care through the emergency department or hospitalization.

INTEGRATION

As our population ages and grows, and technological innovation advances, the number of people living with complex medical issues and multiple conditions such as diabetes, congestive heart failure and chronic obstructive pulmonary disease[32], will go up. The demands on our community-based supports and services will also increase. As a result, there will be greater demand for services that address the entire spectrum of conditions a person experiences and that are integrated across the continuum of care.

People with complex medical issues and multiple conditions need access to information to help them self-manage their ailments, and they also need a simple way to access necessary services. Transitioning from one health care setting to another, these individuals often have trouble navigating to optimize their care. Evidence suggests that strengthening integrated health care delivery across the continuum will result in seamless care delivery and better patient, population and system outcomes. For example, the Virtual Ward[33], an integrated delivery model combining primary care, home care and post-acute (at discharge from hospital) care, lowered hospital readmission rates by 33 per cent and 50 per cent, at 30 and 90 days, respectively.

At the same time, if we can improve the health of residents in Central LHIN at every age through health promotion and disease prevention, there will be less demand on the health system over time. People will remain independent longer and the system will be more sustainable and will be able to serve the needs of our population for generations to come.

PERSON-CENTREDNESS

In September 2011, the Citizens' Reference Panel on Ontario Health Services[34] released its report on priorities for Ontario's health system. This panel of 28 citizens was randomly chosen from a pool of 550 responses from a total of 10,000 invitations to consult on Ontario's health care system. A key panel recommendation was to engage patients as partners:

> *"We want to encourage a culture of patient- and family-centred care throughout Ontario's health system. This means developing a culture in which providers actively respect and respond to patient needs, preferences and values..."*

In a health system that puts people first, health and community service providers are sensitive to the individuality and diversity of the population served, and the individual is involved in all stages of decision making. "Nothing about me without me" is a phrase often used by people who live with the experience of mental health and addictions challenges. It also rings true for "person-centred" care.

32 Chronic obstructive pulmonary disease is the occurrence of chronic bronchitis or emphysema, a pair of commonly co-existing diseases of the lungs in which the airways become narrowed. This leads to a limitation of the flow of air to the lungs, causing shortness of breath. In contrast to asthma, this limitation is poorly reversible and usually gets progressively worse over time.

33 Dr. G. Ross Baker – Chair. *Enhancing the Continuum of Care – Report of the Avoidable Hospitalization Advisory Panel.* Submitted to the Ministry of Health and Long-Term Care in November 2011.

34 PricewaterhouseCoopers. *Public Priorities for Ontario's Health System – A Report of the Citizens' Reference Panel on Ontario's Health Services.* September 2011.

Central LHIN's person-centred priorities are based on what people ought to expect from our health care system. Everyone ought to have access to supports that help retain health and independence, not just access services when ill. The ability to access linguistically and culturally adaptive services needs to be improved. We should all have a positive service experience when interacting with the system, and not be passed from one silo into another, often duplicating tests and/or re-telling what ails us to a chain of health professionals. People ought to be involved in decision making about their own health and offered information and options that allow their input to the decision making process.

Our strategy aims to continue to reduce avoidable health disparities within targeted population groups, such as economically disadvantaged neighbourhoods, vulnerable populations, the Aboriginal population, the non-English speaking population and our Francophone communities.

> ***Central LHIN will strive to reduce health disparities as a shared responsibility with its health service providers by integrating health equity into strategies and activities within its mandate and influence.***
>
> **– Central LHIN statement of commitment for reducing health disparities; approved by the Central LHIN Board on March 24, 2009**

Embedding a health equity orientation in local health system policies and practices helps to reduce health disparities among diverse population groups, and reduces the likelihood that decisions and actions will increase existing disparities. Identifying and reducing barriers to access and quality of care for marginalized populations and those with the worst health and least access to resources will result in a more equitable and sustainable health system for all.

Measuring Success

A key component of the IHSP is tracking progress to know when we have succeeded in reaching our goals, and when we need course correction. It allows us to identify which strategies result in the best outcomes and should be spread across Central LHIN, as well as which practices should not continue because they provide minimal or no benefit.

Success will be measured by how well we achieve our goals as indicated by specific performance metrics determined by the Ministry-LHIN Performance Agreement (MLPA), as well as by the provincial and regional system performance indicators that will lead to a high-performing health system. The metrics will address three key areas[35]:

- Patient care and experience;
- Population health outcomes; and
- Cost-effectiveness.

Central LHIN will measure success by:

- Striving to link our outcomes to specific and measurable targets and indicators that are based on MLPA targets and our system performance indicators;
- Regular performance monitoring; and
- Collaborating with our health service providers and communities to address system challenges.

The performance metrics will link Central LHIN's strategic plan with the Annual Business Plan, operations and the accountability agreements for achieving them.

Accountability agreements with our health service providers across the sectors will be key to our success over the next three years. These agreements help to clearly define expectations of both the LHIN and its health service providers, and help us each be accountable for our role in achieving the IHSP 2013-2016 quality-based system directions.

35 Institute for Health Improvement's Triple Aim Framework was developed to optimize health system performance in the three identified areas. For more information, visit www.ihi.org.

Our Appropriateness Strategy			
What we want to do	**How we're going to do it**	**What success looks like**	**What measures will we improve?**
Continue to advance more effective ways to deliver care that improve quality and are safer Offer the most appropriate treatment settings Use more evidence-based decision making	• Maintain and advance quality, safety and effectiveness gains by aligning hospital QIPs with LHIN performance targets • Broaden use of technology such as telemedicine and telehomecare[36] • Continue to advance effective interventions for those with chronic and complex conditions, both in the community and upon hospital discharge (e.g. diabetes, chronic kidney disease, diseases of the circulatory system, respiratory disease) • Offer services in the most appropriate settings, including in the home • Prevent functional decline in seniors while in hospital so they can be discharged back to the community/home rather than to long-term care, when appropriate • Establish a Central LHIN-wide Hospice Palliative Care Network to expand capacity to provide palliative services and pain and symptom management • Develop a maternal-child health plan for Central LHIN • Encourage the spread of care pathways that provide the best outcomes across the LHIN and link to bundled funding based on outcomes (e.g. hip, knee, chronic kidney disease, stroke)	• Improved delivery of quality, safe and effective care to help people remain at home and productive • Increased efficiency in service delivery capacity in the community • Through palliative care, support more patients through the end of life period in their preferred location	• Fewer unplanned return trips to the hospital with a goal of having the actual number of readmissions equal to the expected number of readmissions • Reduce the percentage ALC days by 20 per cent by 2016 • Reduce percentage of 30-day return visits to ED for patients with mental health and substance abuse conditions by 15 per cent by 2016 • 15 per cent more community services for the same funding by 2016 • Reduce the total number of acute hospital days that are attributable to palliative care by 10 per cent by 2016

36 Telehomecare involves the use of electronic devices to collect and transmit information from a patient at home to the patient's health care provider. This enables the health care provider to monitor the patient and see if they require further attention.

Our Access Strategy			
What we want to do	**How we're going to do it**	**What success looks like**	**What measures will we improve?**
Continue to streamline the flow of people through hospitals to make the best use of resources Improve access to primary care Improve access for patients with life and limb threatening illness Make it easier for people to move through the system to access the right care at the right time in the right place	• Improve hospital discharge processes and links to primary care and community care, including mental health and addictions services, incorporating the development of a standardized discharge summary template • Support the implementation of Ontario's Comprehensive Mental Health and Addictions Strategy to enhance access to mental health and addictions services • Broaden the use of technology and interventions, such as telehomecare and rapid response systems[37], to provide supports at home and prevent 30-day readmissions for high risk patients • Support the fast-tracking of "advanced access" in primary care (improve access to same/next day appointments when patients need them) • Use technology to speed up referrals and shorten wait lists, for example e-referral solutions and needs assessment tools, which includes collaboration with neighbouring LHINs • Implement Life and Limb "no refusal" Policy to ensure access to tertiary care resources for unstable patients with life or limb-threatening conditions • Create a system-wide process to access rehabilitation, transitional and convalescent care beds in the LHIN • Provide more access to supports for people with complex medical needs in appropriate community settings as people transition from the child and youth system to the adult health system	• Wait times for access to primary health care, community, mental health and addictions and hospital services, including surgical and diagnostic services, will be reduced by moving patients through the system to receive care in the right settings	• Hold the gains or maintain the current rate for the number of Emergency visits/1,000 population for conditions that could be treated in alternative primary care • Improve the 90th percentile emergency room length of stay for admitted patients by 20 per cent while maintaining the 90th percentile emergency room length of stay for low complexity and high complexity patients • For more complex patients, increase the number of booked appointments with their primary care provider within seven days of hospital discharge by 30 per cent • Reduce the number of complex vulnerable patients actively looking for a primary care provider by 50 per cent by 2016 • Reduce home care 90th percentile wait times from application to service initiation for CCAC services by 15 per cent by 2016 • Reduce percent of ALC days for hip fracture and stroke patients awaiting rehabilitation by 30 per cent • Maintain surgical and diagnostic wait times performance

37/ A rapid response team offers acute care at home even though an individual remains under the care of a hospital team or family care provider. As an example, a rapid response nurse provides the first in-home nursing visit to patients with high risk conditions within 24 hours of being discharged from hospital. The team helps patients with the transition from acute hospital care to home care – connecting them with the care they need and ensuring the appropriate medication use – reducing the risk of hospital readmission.

Our Integration Strategy			
What we want to do	**How we're going to do it**	**What success looks like**	**What measures will we improve?**
Create an integrated local system of care Improve transitions of care across the health care continuum Support patients with complex needs at high risk for hospital admission in gaining access to an integrated team of providers to address their needs	• Identify and pilot natural geographic hubs of health care providers based on referral patterns, and develop processes that optimize integrated care delivery across the continuum in a person-centred manner • Create ways to integrate primary care planning into the LHIN, including planning tables that include both primary care and public health • Develop processes to engage primary care in public health initiatives • Improve ways of identifying those at high risk for admission to hospital, including people with complex needs (e.g. frail seniors, people with multiple medical issues), and provide access to complex coordinated care across the continuum to support smooth care transitions • Use electronic tools (e.g. Hospital Report Manager[38]), Integrated Assessment Record[39], e-referral, Electronic Medical Record[40], and other electronic methods to share information across providers • Put into action a single plan of care for those with complex needs that links across all providers, including primary health care, involved in the patient's care • Establish discharge protocols that link primary care to acute and post-acute care, rehabilitation and community services, incorporating the development of a standardized discharge summary template • Develop a single source of information for community service providers in the LHIN • Create a common set of tools to identify high risk patients and establish best practices and care pathways to address their needs • Educate primary care providers about community services available in the LHIN • Spread care pathways that provide the best outcomes across the LHIN and link to bundled funding based on outcomes (e.g. hip, knee, chronic kidney disease, stroke)	• Improved care coordination across the health system for those who most need it and better transitions from hospital to community and primary care • Through technology, patient information will be used by health service providers to provide appropriate care	• For more complex patients, increase the number of booked appointments with their primary care provider within seven days of hospital discharge by 30 per cent • Fewer unplanned return trips to the hospital with a goal of having the actual number of readmissions equal to the expected number of readmissions • Establish integrated communities of providers, including mechanisms for including public health, across the LHIN by 2016

38 Hospital Report Manager (HRM) is an electronic tool that provides physicians with the most up-to-date information about their patients' medical information from their hospital encounters.

39 The Integrated Assessment Record (IAR) is an application that allows authorized users to view a consenting client's assessment information to effectively plan and deliver services to that client. The IAR allows assessment information to move with a client from one health service provider (HSP) to another. HSPs can use the IAR to collaborate with other care providers and to view timely assessment information electronically, securely and accurately.

40 An Electronic Medical Record (EMR) replaces paper-based medical records. This comprehensive electronic record of a person's medical history can be made readily available to doctors, specialists and other clinicians involved in treatment and care.

Our Person-Centredness Strategy			
What we want to do	**How we're going to do it**	**What success looks like**	**What measures will we improve?**
Keep our population healthy Promote knowledge and self-management of chronic diseases Promote equitable access to health services Improve the patient experience when accessing health services	• Collaborate with Public Health units to promote active lifestyles, healthy eating and reduce childhood obesity • Collaborate with the education system and child/youth services to provide mental health and addictions supports in schools • Work with the community to promote holistic, cross-sectoral strategies to address social determinants of health in at risk populations (e.g. persons living with mental health and addictions issues, Aboriginal Community, South Simcoe / Northern York Region (i.e. Georgina) and North York West (i.e. the Jane/Finch corridor) • Collaborate with municipalities to promote *Senior Friendly* communities of care • Establish a model for **Senior Friendly Hospitals**[41] • Use technology (e.g. telemedicine, telehomecare) to improve access to services in rural communities and the Aboriginal population • Use technology to increase access to interpretation services for non-English speaking and Francophone populations • Develop/expand outreach programs to improve screening/detection of patients with diabetes/prediabetes in high risk areas (e.g. North York West) • Incorporate patient/community participation in Central LHIN planning activities • Central LHIN will collaborate with Entité4 to improve access to linguistically and culturally adaptive health care services for the Francophone community • Promote educational resources on chronic disease self-management • Set up a central resource of information on services available in the LHIN and educate primary care providers and the public • Employ patient experience surveys to see how well we are delivering person-centred care	• Maintain the number of people who have a positive experience when accessing health services • People will have greater opportunities to receive services in a language that they can understand • People can more easily access self-management tools and information about services for chronic diseases • People actively participate in their care choices	• To be developed – working with health service providers to determine measures • Reduce the percentage of ALC for patients waiting for long-term care by 15 per cent by 2016 • Increase availability of interpretation services to non-English speaking residents, including Francophones and Aboriginals by 30 per cent by 2016 • Utilize the integrated communities to support the development of self-management skills for patients and families • Increase the number of family physicians providing advanced access[41] scheduling for their patients by 20 per cent by 2016

41 Senior Friendly Hospitals improve the health, well-being and experience of seniors in Ontario hospitals, helping them get back home sooner and healthier. They improve seniors' ability to live independently and stay out of hospital, improve the use of health care dollars, help reduce ALC through supporting people to transition to the right place of care after a hospital stay and promote quality improvement initiatives that can be included in hospital Quality Improvement Plans as part of the *Excellent Care for All Act, 2010*.

Enablers

The four enablers that will help us reach our goals are:

- Health System Funding Reform and Strategic Investments;
- Information Technology / Information Management;
- Health Human Resources; and
- Community-based quality improvement plans and Performance Measurement/Public Reporting.

Health system funding reform and strategic investments in key initiatives will enable our system transformation goals. Over the next three years, health care organizations will be funded based on how many patients they look after, the services they deliver, the evidence-based quality of those services and the specific needs of the broader population they serve. This will help shift spending to where we can get the best value.

Information technology and information management play a key role in integrating the various sectors of the healthcare system. This eliminates duplication, allowing service providers to share information and coordinate services quickly and efficiently so that data is not lost as people transition through the care continuum. It also supports performance evaluation and allows planning decisions to be made based on evidence obtained through electronic systems.

Supporting the development of capacity in **health human resources** will help us deliver on our goals. As our population grows, we may need more health and community care professionals to serve local needs. Understanding how and where our population receives services and matching capacity to needs will support a balance between the demand for services and the types of services available in Central LHIN.

Supporting the development of quality improvement plans with shared accountabilities among providers will be an important focus. The systematic performance evaluation and public reporting on system performance will also raise awareness of the impact of our programs and foster evidence-based decision making.

6 CHAPTER

Conclusion

Putting it all together

Achieving the targets within each of our quality-based system directions – Appropriateness, Access, Integration and Person-Centredness, will require partnerships with the Ministry of Health and Long-Term Care (MOHLTC) and other LHINs (particularly in the Greater Toronto Area), as well as across the entire health care community, whether or not the stakeholders are within the scope of LHIN responsibility.

We will need to align and coordinate our efforts with related projects and government priorities and work to create collaborative opportunities, rather than duplicate efforts. With more care moving into the community and away from acute care, we will need to encourage greater collaboration and integration among providers to ensure that people in our communities receive the right care at the right time and in the right place.

For Central LHIN, this means we will also need to continue to partner with municipalities, the Ministry of Community and Social Services, the Ministry of Children and Youth Services, and the Ministry of Education on targeted initiatives that improve the social determinants of health, including education, employment and housing.

Four key enablers – **Health System Funding Reform and Strategic Investments, Information Technology/Information Management, Health Human Resources,** and **Community-based quality improvement plans and Performance Measurement/ Public Reporting,** will provide the necessary tools to effect local system changes that can move us closer to our vision of *Caring Communities – Healthier People.*

Finally, tracking and publicly reporting on our collective results will help us all see where our LHIN is making gains in improving health care and where we need to continue to improve. This will allow us to share and celebrate successes with our health service providers and our communities, and together, build upon our achievements.

Managing Risk

As system planners, we seek to manage risk by determining ahead of time any issues that could negatively impact our plans or stop us from achieving our goals. Central LHIN has identified a number of issues that could affect our success in implementing the system directions of our Integrated Health Service Plan (IHSP). They include:

HEALTH HUMAN RESOURCES

Recruiting and retaining appropriate health human resources will continue to be a challenge for our providers. According to our Health Human Resources Risk Reduction Plan Final Report, 2008, an aging health work force (excludes physicians) will pose difficulties as approximately half of all employees of Central LHIN providers are above the age of 45, with 18 per cent over the age of 55. To address this risk, we will continue to look for ways to partner with each other to reduce gaps and improve linkages amongst health service providers, as well as explore opportunities to create additional capacity. We will look to the MOHLTC to take a more holistic approach to this provincial challenge.

According to the Ontario Physician Human Resources Data Centre, *2011 Physicians in Ontario* report, there is one physician per 1,224 residents, somewhat higher than the provincial average of one physician per 1,124 residents, indicating a lower number of primary care physicians in Central LHIN than on average in the province. In order to manage the risk, HealthForceOntario Marketing & Recruitment Agency (HFO) provides a Regional Advisor situated in Central LHIN to provide recruitment support for primary care and specialists. The Advisor addresses distribution of physicians in the LHIN and focuses recruitment efforts on high need areas. HFO also works with Ontario medical schools and residency training sites in Central LHIN to retain physicians in the region. Our percentage of unattached patients is lower than the provincial average.

FINANCIAL CONSTRAINTS

Our four quality-based system directions align with MOHLTC priorities. Just as the ministry must balance competing priorities at the provincial level, the LHIN must balance our four system directions, making the best use of the limited resources we have in the current climate of fiscal restraint.

Using measurable targets helps us establish the extent to which program objectives are achieved. We monitor and evaluate programs and services and analyze performance indicators to track compliance and determine opportunities for improvement.

STAKEHOLDER CONCERNS

Everyone who lives, works, delivers and/or receives care in Central LHIN has a stake in the local health system. We remain committed to engaging openly with stakeholders – from the people who manage and deliver health and community support services, to MPPs, municipal governments, community groups, special interest organizations, and people who receive care from our health service providers. We actively seek input from stakeholders, listen to concerns and incorporate the input we've heard into our implementation plans at the earliest stages possible.

Our Ministry-LHIN Performance Agreement (MLPA) – available at www.centrallhin.on.ca – defines our relationship with the Ministry of Health and Long-Term Care, and outlines performance indicators we will strive to meet.

Annual Business Plans

The Central LHIN IHSP 2013-2016 will be the focus of our activities and local investments over the coming three-year period. Working together with our health service provider partners, Central LHIN will develop Annual Business Plans outlining specific action plans and performance measures related to each of the four quality-based system directions identified in the IHSP 2013-2016.

Central LHIN residents and health system users benefit every year from the investments made in our local health system. We are determined that the care provided over the next three years will achieve our quality-based system directions to improve appropriateness, access, integration and person-centredness within a strategic framework that supports the development of integrated health service provider communities that work together to improve care. We are counting on our local partners to join with us and collectively bring our new strategic plan to life.

Together, We're Better.

Additional Resources

The following information was valuable to inform Central LHIN as we developed our Integrated Health Service Plan 2013-2016

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